PRINTED: 10/31/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E015	B. WIN	IG		10/3	0/2012
	ROVIDER OR SUPPLIER	тси	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
F 241 SS=D	Health Resurvey. 483.15(a) DIGNITY A INDIVIDUALITY  The facility must promanner and in an enventances each reside full recognition of his  This REQUIREMENT by: The facility identified The sample included observation and interprovide dining in a digdining rooms for 1 outside included: - During initial dining	note care for residents in a vironment that maintains or ent's dignity and respect in	F	241			
	un-sampled resident the lunch meal. He/S another table in the d another un-sampled that resident.  During interview on 1 administrative nursing should sit and visit will assisting to feed then	and fed the resident part of he then walked over to ining room and stood over resident and began feeding  0/25/12 at 10:37 A.M. g staff D reported staff the residents while n. Standing while feeding ered a dignity issue and was					
		ovide a policy to address					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	=		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G		10/36	0/2012
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F 241	Continued From page dignity in dining.  The facility failed to p environment.	e 1 rovide a dignified dining	F	241			
F 279 SS=D	483.20(d), 483.20(k)( COMPREHENSIVE Of A facility must use the	ARE PLANS e results of the assessment	F	279			
	comprehensive plan						
	plan for each resident objectives and timeta medical, nursing, and	elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive					
	to be furnished to atta highest practicable ph psychosocial well-bei §483.25; and any ser be required under §48 due to the resident's a	-					
	by: The facility identified The sample included observation, interview facility failed to developlan for 2 of 10 reside	a census of 29 residents. 23 residents. Based on and record review the pp a comprehensive care ents sampled for ions, #3 for pain and #24 for					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER:  A. BUILDI			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	10/01/12 recorded dia pain, fibromyalgia and could cause musculor ordered staff to give the milligrams three times. Lidoderm 5% pain pathe resident's feet at little The quarterly Minimu 8/08/12 documented constantly and in the assessment the pain. The resident received medications.  The Care Area Assess 2/29/12 documented pain of the knees and Tylenol three times dia patch (a topical pain of the the resident had did not provide a descipain. Staff did not car scheduled Tylenol 32 daily for pain or the Licare plan did not direct effectiveness of the peffects from the lidode lacked appropriate no interventions.	cian's Order sheet dated agnoses of colon cancer, darthritis (diagnoses which skeletal pain). The physician he resident Tylenol 325 s daily for pain and apply a tch, one half of a patch to be time.  Im Data Set (MDS) 3.0 dated the resident had pain almost 5 days prior to the limited day to day activities. I scheduled pain  I scheduled pain  I shoulders and received aily and used a Lidoderm medication patch) at night.  B/16/12 failed to direct staff pain almost constantly and cription of the resident's	F	279			

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F 279	a wheelchair feeding  During interview on 1 administrative nursing use non-pharmacolog as hot packs and the for pain management those interventions. The Lidoderm patch a He/She acknowledge medications were not type and location of p  The facility failed to d	e dining room at the table in himself/herself.  0/25/12 at 10:37 A.M. g staff D reported staff did gical pain interventions such hydrocolator (a device used ), but did not care plan he resident started using long time ago for pain. d the specific pain on the care plan and the ain was not addressed.	F 2	79		
	(MDS) 3.0 dated 8/15 resident with short an problems. The reside medication within the MDS.  The significant chang (CAA) for antipsycholdocumented the reside psychotropic medicat disease with increase.  The comprehensive of failed to direct staff or displayed or that the light (an anti-psychotic medicat compared to the comprehensive of the comprehensive of the comprehensive of the comprehensive of the compared to the compared	d long term memory nt received an antipsychotic last 7 days prior to the  e Care Area Assessment ic use dated 5/22/12 lent received several ions and had Alzheimer's				

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F 279  F 280 SS=D	to give the resident Z bed time for paranoia. The current Behavior documented daily bel angry outbursts, resis abusive and restlessr. Observation on 10/25 the resident slept in b. During interview on 1 administrative nursing resident started taking staff did not care plan after staff completed. The facility failed to care plan for medication for this resident to care plan for medication for this resident has the incompetent or otherwincapacitated under the participate in planning changes in care and the comprehensive assessinterdisciplinary team physician, a registere	d to taking Zyprexa.  d's Order Sheet ordered staff yprexa 2.5 milligrams every  Management Sheet havior monitoring by shift for stive to cares, physically ness.  d/12 at 8:02 A.M. revealed ed.  0/25/12 at 10:37 A.M. g staff D reported the g Zyprexa on 7/23/12 and the resident for the Zyprexa the last MDS.  are plan for behaviors and scheduled antipsychotic sident.  k)(2) RIGHT TO  NING CARE-REVISE CP  right, unless adjudged wise found to be ne laws of the State, to g care and treatment or treatment.  e plan must be developed e completion of the sament; prepared by an that includes the attending d nurse with responsibility	F 27			
	During interview on 1 administrative nursing resident started taking staff did not care plan after staff completed. The facility failed to care plan for medication for this resident has the incompetent or otherwincapacitated under the participate in planning changes in care and the comprehensive care within 7 days after the comprehensive assessinterdisciplinary team physician, a registere	0/25/12 at 10:37 A.M. g staff D reported the g Zyprexa on 7/23/12 and the resident for the Zyprexa the last MDS.  are plan for behaviors and scheduled antipsychotic sident. k)(2) RIGHT TO NING CARE-REVISE CP  right, unless adjudged wise found to be ne laws of the State, to g care and treatment or treatment.  e plan must be developed e completion of the ssment; prepared by an , that includes the attending	F 28	30		

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F 280	and, to the extent pra the resident, the resident legal representative;	e 5 ined by the resident's needs, cticable, the participation of dent's family or the resident's and periodically reviewed n of qualified persons after	F	280			
	by: The facility reported The sample included observation, record re	is not met as evidenced a census of 29 residents. 23 residents. Based on eview, and staff interview, vise the care plan for 1 ed.					
	9/5/12 for resident #1 for Mental Status (BII impaired cognition); vup or physical help for transfer, walk in room unit, and eating; required exting person with dreshygiene; required extiperson with bathing; device; was occasion frequently incontinent developing pressure reducing device for control to the Care Area Assessment of the Care Area Assessment in the Car	am Data Set (MDS) dated 0 revealed a Brief Interview MS) score of 8 (moderately was independent with no set om staff for bed mobility, n/corridor, locomotion on/of ired limited assistance of sing, toilet use, and personal ensive assistance of one used a walker for mobility ally incontinent of urine; at of bowel; was at risk for ulcers; used a pressure hair/bed, and nutrition or a to manage skin problems.					

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F 280	10 areas; required limitoileting, and personal May; and depression ADLs.  The care plan dated State documentation the retherapy.  The Physician's Order revealed orders for oxider annula PRN.  The Telephone Order orders for oxiders for oxygen per liters when oxygen per liters when oxygen sapercent (%) PRN.  Observation on 10/23 the resident sat on a station and used oxygen observation on 10/23 the resident returned ambulating from her/mursing staff H who per back on the resident.  Staff interview on 10/2 licensed nursing staff updated resident car and significant chang.	the independent with 7 out of nited assist with dressing, all hygiene; had no falls since could affect the resident's  2/13/12 lacked sident received oxygen  The Sheet dated 10/1/12 aygen at 3 liters per nasal attractions falls below 90  2/12 at 10:10 A.M. revealed love seat by the nursing gen via nasal cannula.  2/12 at 11:00 A.M. revealed to sit on the love seat after his room with licensed laced the oxygen cannula  2/25/12 at 9:42 A.M. with D stated nursing staff e plans with new orders, es.	F	280			

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F 280	Continued From page	: 7	F	280			
F 309 SS=D	with a revised dated of care was a working to the needs of the residence of the residence of the facility failed to up care plan for oxygen of 483.25 PROVIDE CA HIGHEST WELL BEIL	pdate/revise the resident's use. RE/SERVICES FOR	F	309			
	provide the necessary or maintain the highest mental, and psychoso	y care and services to attain st practicable physical,					
	by: The facility identified The sample included observation, interview facility failed to provid	a census of 29 residents. 23 residents. Based on and record review the le appropriate care and sidents sampled for dialysis					
	Findings included:						
	10/1/12 documented	sician's Order Sheet dated a diagnosis of chronic renal 1500 cubic centimeter per					
		nm Data Set (MDS) 3.0 ed the resident with a Brief					

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F 309	interview for Mental Sindicated the resident resident resident resident resident resident resident received dial disease).  The Care Area Assess dehydration and fluid documented the resident to dialysis received diarrhea and he/she is medication). He/She is encouraged him/her to the resident's room.  The Care Plan dated related to chronic remover the intra-jugular device) to prevent it from the dialysis resident. Facility staff communication sheets  The clinical record con Records from 8/17/12 documentation of bloof from the dialysis cent. Review of the clinical monitoring from the facility arrived back to the facility or monitoring of the indocumented by the staff Review of the Medical Administration Records.	status Score of 15, which had intact cognition. The ysis (a treatment for kidney)  sment (CAA) for maintenance dated 3/14/12 lent at risk for dehydration ed twice weekly, a history of used imodium (anti-diarrheal had congestion and staff to drink out of red glass in  9/6/12 for self care deficit al failure directed staff to r site (central blood access for getting wet. The dialysis sing changes and secenter to monitor the to send the out- patient with the resident to dialysis.  Intained Outpatient Dialysis et a. 10/19/12 with od pressures and weights er.  Intercord revealed a lack of acility after the resident cility following dialysis al signs, nursing assessment extra-jugular site were saff in the clinical record.	F	309			

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F 309	the resident sat in his and watching televisis served breakfast in his need to check him/he of the fluids drank. If he/she would call.  During observation a 9:59 A.M. licensed nowent to dialysis on Tousually returned to the The facility was in conthe dialysis center. Domedication changes, the dialysis site and canything for the residented dialysis site during Staff did not monitor treatments. The residented he/she used to control The facility policy data Dialysis failed to add assessments/monito dialysis.	gular site.  5/12 at 8:00 A.M. revealed s/her room wearing pajamas on. He/She said staff would is/her room. Staff did not er after dialysis or keep track he/she needed a nurse,  and interview on 10/25/12 at curse I reported the resident cuesdays and Fridays and le facility around 4:00 P.M. Instant communication with ialysis did the blood draws, all of the maintenance on did not want the facility to do lent's dialysis. Staff did cover g showers to keep it dry. The resident after dialysis dent kept track of his/her own a red cup in his/her room that on his/her own fluids.  The first staff documentation of ring regarding the resident's	F	309			
F 314 SS=D	of this resident with a		F	314			
		ehensive assessment of a nust ensure that a resident					

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F 314	does not develop pre individual's clinical country were unavoidably pressure sores received services to promote here prevent new sores from the sample included observation, record refacility failed to assist resident sampled for Findings included:  The Physician's Or 10/2/12 for resident #1 dementia (memory procession) for the Annual Minimum 19/5/12 for resident #1	without pressure sores source sores unless the andition demonstrates that de; and a resident having wes necessary treatment and healing, prevent infection and om developing.  To is not met as evidenced as census of 29 residents. A residents. Based on eview, and staff interview the with repositioning of 1 (#10) at risk for pressure ulcers.  The der Sheet (POS) dated the to revealed a diagnosis of roblems).  To Data Set (MDS) dated of revealed a Brief Interview		314	DEFICIENCY)		
	impaired cognition); we up or physical help for transfer, walk in room unit, and eating; requested one person with dress hygiene; required extended person with bathing; device; was occasion frequently incontinent developing pressure reducing device for continents.	MS) score of 8 (moderately was independent with no set om staff for bed mobility, n/corridor, locomotion on/of ired limited assistance of sing, toilet use, and personal ensive assistance of one used a walker for mobility ally incontinent of urine; at of bowel; was at risk for ulcers; used a pressure hair/bed, and nutrition or in to manage skin problems.					

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F 314	Continued From pa	ge 11	F3	314			
	for Activity of Daily I resident was able to 10 areas; required I toileting, and persor The CAA dated 9/10 revealed the resider ulcers at this time; I which healed; sat mon her/his back in b 85.5 pounds.  The care plan dated related to weakness required limited ass for skin breakdown, relieving mattress ochair.  The Braden Scale of 21 for low risk for	essment (CAA) dated 9/10/12 Living (ADL) revealed the be independent with 7 out of imited assist with dressing, hal hygiene.  D/12 for Pressure Ulcers ht did not have any pressure had pressure ulcers in the past huch of the time; usually laid ed; and the resident weighed  1 9/13/12 for self-care deficit s, recorded the resident ist with ADLs; and potential and used a pressure in the bed/cushion on the					
	A.M. revealed the real The NN dated 10/22 resident was incontitutive this morning; productive cough; pin all quadrants; the (IV) therapy of Lasis The ADL log for Augrevealed the resident	(NN) dated 10/21/12 at 9:25 esident's skin was intact.  2/12 at 9:05 A.M. revealed the inent of bowel and bladder the resident still had a hlegm clear; lungs had rales resident received intravenous k.  gust and September 2012 of was continent/incontinent of independent with toileting;					

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F 314	used a pressure relie ambulated with a wa able to transfer self.  The ADL log for Octoresident was both co and bladder; used a while in bed/couch; a assistance of one.  Observation on 10/20 the resident sat on a reducing cushion preservation on 10/20 the resident ambulate room with licensed in front wheel walker with the resident returned ambulated from her/nursing staff H did not reducing cushion on Observation on 10/20 the resident slept on station; and there was cushion in place.  At 12:45 P.M. reveals her/his head bent to arm of the couch; a cushion on seat.  At 1:00 P.M. reveals her/his head bent to a cushion on seat.	eving device in bed; lker independently; and was  ober 2012 revealed the intinent/incontinent of bowel pressure reducing device and self transfered with the  3/12 at 10:10 A.M. revealed couch seat; no pressure isent/used.  3/12 at 10:38 A.M. revealed ded in the hallway to her/his ursing staff H and used a ith stand by assist.  3/12 at 11:00 A.M. revealed to the couch after he/she his room, and licensed of place the pressure the couch.  3/12 at 12:30 P.M. revealed the couch at the nursing is no pressure reducing  ded the resident slept with the left and resting on left chair cushion was at her/his no pressure reducing  d the resident slept with the left and resting on left d no pressure reducing	F3	14			

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F 314	glasses could get ber the resident to toilet; at the seat.  At 1:45 P.M. revealed her/his head bent to to left arm of the couch; wakened the resident did not encourage the pressure cushion on the terms of the did not encourage the pressure cushion on the terms of the did not encourage the pressure cushion in understed on the lepressure cushion in understed on the left arm of the cushion in use.  At 3:00 P.M. the resident of the cushion in use.  At 3:05 P.M. direct caresident; repositioned encouraged the resident pressure reducing custon; and encouraged to supplement.  At 3:15 P.M. the resident supplement.	I direct care staff P Int with concerns his/her eye int; staff did not encourage and no pressure cushion on  I the resident slept with the left and resident on the licensed nursing staff H to give her/him medication; e resident to toilet; and no the seat.  I the resident slept on the int to the left and her/his ft arm of the couch; and no se.  I the resident slept on the int to the left and her/his ft arm of the couch; and no se; administrative staff A is eye glasses.  I the resident slept on the int to the left and her/his ft arm of the couch; and no se; direct care staff O and offered him/her a ot encourage toileting. I left and her/his head rested couch; and no pressure  The staff P awakened the	F	314			

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	ROVIDER OR SUPPLIER	тси	'	33	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572	, ,,,,,	
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F 314	At 3:30 P.M. the resist the couch and pressured to her/his own; remoused her/his walker at the hallway into the blicensed nursing staff and provided pericare below the coccyx are licensed nursing staff were wet with urine; the diarrhea and received.  Staff interview on 10/licensed nursing staff sit on the couch; got cushion on the couch applied a barrier creat PRN; skin checked we applied cream; and it staff informed her/him.  Staff interview on 10/direct care staff Q states sick, staff tried to told before getting sick, the her/himself; reposition used to come into the not do that since shew barrier cream; staff of the bath tub and with inform the nurse if she and was not often income Staff interview on 10/ladministrative nursing was occasionally income staff occasionally income staff interview on 10/ladministrative nursing was occasionally income.	dent was awake and sat on are reducing cushion. dent got up from the couch wed her/his oxygen cannula; and slowly ambulated down athroom and voided; I went into the bathroom, as; dark pink area noted as; applied barrier cream; I stated the resident's briefs the resident had chronic d Imodium.  25/12 at 9:42 A.M. with I stated the resident liked to up on her/his own; used a to prevent pressure ulcers; and three times daily and with ADL and when staff was her/his expectation of any opening on the skin.  25/12 at 10:09 A.M. with atted since the resident was bet her/him every two hours; he resident went by the devery two hours; he deve	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E015	B. WING		10/3	0/2012
	OVIDER OR SUPPLIER	тси	s	TREET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	cream/pressure reduction like to sit on the pressure and currently used a like to sit on the pressure development of the policy and proceed 4/09 for Prevention/Tour Pressure Ulcers reversioned be implemented identified as at risk; in application of pressure skin clean and dry; and ambulation/activity.  The facility failed to erepositioning for this reducers.	eting program; used a barrier cing mattress; and did not sure reducing pad/cushion pillow to sit on.  dure with the revised dated reatment of Patient with aled preventive measures d as a resident was a resident was a reduction devices, keep and encourage	F 31			
SS=E	Each resident's drug unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate more indications for its use adverse consequences should be reduced or combinations of the resident, the facility may be a diagnosed and do record; and residents	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		475045					
NAME OF PR	OVIDER OR SUPPLIER	17E015				10/3	0/2012
	MEMORIAL HOSPITAL I	TCII			EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268		
GRISELL	MEMORIAL HOSFITAL I			R	ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Continued From page behavioral intervention contraindicated, in an drugs.		F	329			
	by: The facility identified The sample was 23 r observation, record re the facility failed to id irregularities for 10 (# 3, and #30) of 10 resi medication review.	eview, and staff interview, entify medication £12, 25, 23, 15, 21, 4, 2, 24,					
	Set (MDS) 3.0 dated Interview for Mental S severely impaired. The with Activities of Daily of care occurred 1 to period. Staff administ	cant change Minimum Data 9/12/12 recorded a Brief Status (BIMS) score of 3, ne resident was independent y Living (ADL), and rejection 3 days during assessment tered antianxiety, diuretic medications to the					
	side effects for any or the resident.  During an interview of licensed nursing staff had questions or con	or the medication of the medications staff gave on 10/24/12 at 9:58 A.M., of H stated when the nurses cerns about medication side d the medication book, went					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI				
		17E015	B. WIN	<u> </u>		10/3	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3:	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the facindividualized medicathe resident.  The facility-provided provided in Medication Side Effect to refer to the drug has for monitoring of all monline program Lippin Some of the charge mapplication on their permedication side effect report any unusual syor long term care supperviewed medication notified the practition nurse did a monthly resident. Facility staff the completion of the addressed medication summary.  The facility failed to meffects for this resident.  Resident #12 Annu 3.0 dated 8/8/12 recomemory problems, kr and had moderately icognitive skills. Staff accommendation of the staff and moderately icognitive skills. Staff accommendation staff and moderately icognitive skills. Staff accommendation in the staff and moderately icognitive skills. Staff accommendation in the staff accommendatio	Nursing Drug Advisor, or ver with other nurses. If H also consulted his/her for medication side effect I nursing staff H stated when seemed different than usual ne resident before staff gave sed nursing staff H cility did not have stion side effects listed for coolicy entitled Monitoring of cts (undated) directed staff andbook at the nurse's desk nedication side effects or the neott's Nursing Drug Advisor. Nurses had a triage ersonal phones to look up tts. Staff members would emptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each f used a tickler file to assure monthly summary. Staff in side effects in the	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E015	B. WIN	G	<del> </del>	10/30	0/2012
	OVIDER OR SUPPLIER	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	side effects for any of the resident.  During an interview o licensed nursing staff had questions or conceffects they consulted online to Lippincott's talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the facindividualized medicathe resident.  The facility-provided properties to refer to the drug has for monitoring of all monline program Lippin Some of the charge mapplication on their permedication side effect report any unusual sy or long term care sup reviewed medication notified the practitions nurse did a monthly resident. Facility staff the completion of the addressed medication summary.	cked evidence of medication the medications staff gave  In 10/24/12 at 9:58 A.M., H stated when the nurses cerns about medication side I the medication book, went Nursing Drug Advisor, or wer with other nurses. If H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual me resident before staff gave sed nursing staff H sility did not have tion side effects listed for coolicy entitled Monitoring of the (undated) directed staff (undated) direc	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E015	B. WIN	G		10/3	0/2012
	OVIDER OR SUPPLIER	тси		3:	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	(MDS) 3.0 dated 10/1 Interview for Mental S which indicated mildly resident required sup dressing and was ind areas of Activities of I administered antianxi anticoagulant, and did resident.  The clinical record lad side effects for any of the resident.  During an interview o licensed nursing staff had questions or cond effects they consulted online to Lippincott's I talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the fact individualized medicate the resident.  The facility-provided p Medication Side Effect to refer to the drug ha for monitoring of all monline program Lippin Some of the charge medicates.	erly Minimum Data Set 7/12 recorded a Brief Status (BIMS) score of 8, v impaired cognition. The ervision and setup with ependent with all other Daily Living (ADL). Staff ety, antidepressant, uretic medications to the  sked evidence of medication of the medications staff gave  an 10/24/12 at 9:58 A.M., H stated when the nurses cerns about medication side of the medication book, went bursing Drug Advisor, or over with other nurses. If H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual he resident before staff gave sed nursing staff H cility did not have tion side effects listed for  policy entitled Monitoring of cits (undated) directed staff andbook at the nurse's desk hedication side effects or the heott's Nursing Drug Advisor.	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF	
		17E015	B. WIN	IG_		10/3	0/2012
	OVIDER OR SUPPLIER	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	, ,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	medication side effect report any unusual sy or long term care sup reviewed medication notified the practitions nurse did a monthly resident. Facility staff the completion of the addressed medication summary.  The facility failed to meffects for this resident  - Resident #2's signiff Set (MDS) 3.0 dated resident as severely cresident required tota transfers, locomotion dressing, toilet use, posthing, and required for bed mobility and einsulin, antipsychotic medications to the resident.  During an interview of licensed nursing staff had questions or conceffects they consulted online to Lippincott's lated the situation of Licensed nursing staff telephone application information. Licensed the resident acted or	ts. Staff members would imptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each if used a tickler file to assure monthly summary. Staff in side effects in the monitor medication side ent.  Ticant change Minimum Data 7/18/12 recorded the cognitively impaired. The last staff assistance for on and off the unit, ersonal hygiene and extensive staff assistance ating. Staff administered and antidepressant sident.  Sicked evidence of medication is the medications staff gave in 10/24/12 at 9:58 A.M., H stated when the nurses cerns about medication side if the medication book, went Nursing Drug Advisor, or ver with other nurses. If H also consulted his/her for medication side effect nursing staff stated when seemed different than usual ne resident before staff gave	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	ROVIDER OR SUPPLIER	тси		330	ET ADDRESS, CITY, STATE, ZIP CODE OS VERMONT PO BOX 268 INSOM, KS 67572	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	the resident.  The facility-provided provided pr	cility did not have tion side effects listed for coolicy entitled Monitoring of cits (undated) directed staff andbook at the nurse's desk dedication side effects or the coott's Nursing Drug Advisor. The staff and sta	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	OVIDER OR SUPPLIER	тси	·	33	EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	had questions or cone effects they consulted online to Lippincott's talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the facindividualized medicathe resident.  The facility-provided professional monitoring of all monline program Lippin Some of the chargen application on their permedication on their permedication side effect report any unusual sy or long term care sup reviewed medication notified the practitions nurse did a monthly resident. Facility staff the completion of the addressed medication summary.  The facility failed to meffects for this resident.	H stated when the nurses beens about medication side of the medication book, went worsing Drug Advisor, or wer with other nurses. If H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual the resident before staff gave sed nursing staff H stility did not have tion side effects listed for coolicy entitled Monitoring of the sedication side effects or the did to the sedication side effects in the	F	329			
		cian's Order sheet dated agnoses of colon cancer,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	IG_		10/30	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	effect the musculoske cause pain). The physical daily for pain and approach, one half of a pabed time. The physical administer Exelon (for bowel), Prilosec (for under the form of the for	d arthritis (diseases which eletal system and could sician ordered staff to give 25 milligrams three times ly a Lidoderm 5% pain atch to the resident's feet at an also ordered staff to recognition), Miralax (for elect treatment), Allopurinol Metoprolol (for blood and Lantus insulins to the match the resident had pain almost 5 days prior to the limited day to day activities. Eduled pain medications.  Sment (CAA) for pain dated the resident had chronic shoulders and took Tylenol used a Lidoderm patch (and patch) at night.  8/16/12 failed to direct staff pain almost constantly and cription of the resident's eplan the resident's eplan the resident's eplan the resident's to monitor for the ain medications. The care the non-pharmacological cility staff failed to included on monitor related to the use	F	329			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G	·	10/3	0/2012
	OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	the resident sat in the a wheelchair feeding.  During interview on 10 administrative nursing use non-pharmacolog as hot packs and the for pain management those interventions. The lidoderm patch a lidoderm patch	dining room at the table in himself/herself.  0/25/12 at 10:37 A.M. Is staff D reported staff didical pain interventions such hydrocolator (a device used ), but did not care plan he resident started using ong time ago for pain. If the specific pain on the care plan and the ain was not addressed. Dication which they could all side effects of was a drug reference book station. Staff did not care ons and side effects for hindividual resident for	F	329			
	(MDS) 3.0 dated 8/15 resident with short an problems. The reside medication within the MDS.  The significant chang	d long term memory  nt received an antipsychotic  last 7 days prior to the  e Care Area Assessment					
	(CAA) for antipsychot documented the resid						

NAME OF PROVIDER OR SUPPLIER  GRISELL MEMORIAL HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES BY PRECIDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 25 psychotropic medications and had Alzheimer's disease (a disease that effects cognition) with increased behaviors.  The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (a medication used to treat psychosis). The care plan lacked direction for staff to monitor behaviors for side effects related to taking Zyprexa. The care plan did not direct staff on the Black Box Warning (BBW) for Zyprexa indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death.  The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia.  Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts, resistive to cares, physically abusive and		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
GRISELL MEMORIAL HOSPITAL LTCU  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 25 psychotropic medications and had Alzheimer's disease (a disease that effects cognition) with increased behaviors.  The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (a medication used to treat psychosis). The care plan lacked direction for staff to monitor behaviors for side effects related to taking Zyprexa. The care plan did not direct staff on the Black Box Warning (BBW) for Zyprexa indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death.  The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia.  Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts,			17E015	B. WIN	G		10/3	0/2012
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 25 psychotropic medications and had Alzheimer's disease (a disease that effects cognition) with increased behaviors.  The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (a medication used to treat psychosis). The care plan lacked direction for staff to monitor behaviors for side effects related to taking Zyprexa. The care plan did not direct staff on the Black Box Warning (BBW) for Zyprexa.  The United States (US) Food and Drug Administration (FDA) issued BBW for Zyprexa indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death.  The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia.  Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts,			тси	•	33	30 S VERMONT PO BOX 268		
psychotropic medications and had Alzheimer's disease (a disease that effects cognition) with increased behaviors.  The comprehensive care plan dated 8/23/12 failed to direct staff on what behavior the resident displayed or that the resident received Zyprexa (a medication used to treat psychosis). The care plan lacked direction for staff to monitor behaviors for side effects related to taking Zyprexa. The care plan did not direct staff on the Black Box Warning (BBW) for Zyprexa.  The United States (US) Food and Drug Administration (FDA) issued BBW for Zyprexa indicated residents with dementia related psychosis treated with anti-psychotic medications were at an increased risk of death.  The current Physician's Order Sheet ordered staff to give the resident Zyprexa 2.5 milligrams every bed time for paranoia.  Behavior Management Sheet documented daily behavior monitoring by shift for angry outbursts,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
restlessness.  Observation on 10/25/12 at 8:02 A.M. revealed the resident slept in bed.  During interview on 10/25/12 at 10:37 A.M. administrative nursing staff D reported the resident started taking Zyprexa on 7/23/12 and staff did not care plan the resident for the Zyprexa after staff completed the last MDS. He/She acknowledged the care plan failed to direct staff to monitor the resident's behaviors or to monitor	F 329	psychotropic medicat disease (a disease the increased behaviors.  The comprehensive of failed to direct staff or displayed or that the immedication used to troplan lacked direction behaviors for side effect Zyprexa. The care plan Black Box Warning (E. The United States (U. Administration (FDA) indicated residents with were at an increased. The current Physician to give the resident Zibed time for paranoia Behavior Management behavior monitoring by resistive to cares, phyrestlessness.  Observation on 10/25 the resident started taking staff did not care plan after staff completed acknowledged the care.	ions and had Alzheimer's hat effects cognition) with are plan dated 8/23/12 in what behavior the resident received Zyprexa (a reat psychosis). The care for staff to monitor rects related to taking an did not direct staff on the BBW) for Zyprexa.  S) Food and Drug rissued BBW for Zyprexa th dementia related in anti-psychotic medications risk of death.  I's Order Sheet ordered staff ryprexa 2.5 milligrams every residually abusive and  Al 2 at 8:02 A.M. revealed red.  O/25/12 at 10:37 A.M. revealed red.	F	329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUF	
		17E015	B. WIN	G_	<del></del>	10/3	0/2012
	OVIDER OR SUPPLIER	тси	ı	3	REET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572	1070	<b></b>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	for the Black Box War The facility failed to m receiving an antipsych Black Box Warning (a	rning side effects.	F	329			
	10/01/12 ordered staf milligrams three times Clonazepam 0.5 millig anxiety.  The quarterly Minimu 9/12/12 recorded the antipsychotic and ant	sician's Order Sheet dated if to administer Meclizine 25 is daily for dizziness and grams three times daily for im Data Set (MDS) 3.0 dated resident received ianxiety medication 7 days is prior to the assessment.					
	The admission Care A psychotropic medicat the resident recently I hospital stay prior to a several psychotropic	Area Assessment (CAA) for ions dated 6/26/12 recorded returned from a psychiatric admission and received medications. The resident I Clonazepam for several					
	alteration directed state and monitor for side of and perform the behat did not list what the performedication were that comprehensive care the resident took school.	ff to administer Clonazepam effects of the medications vior management plan, but otential side effects of the staff should monitor for. The plan did not direct staff that eduled Meclizine three times of the staff on what side					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WING	€		10/3	0/2012
	OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page The October 2012 Be monitored behaviors a medication assessme what specific behavio which medications.  Observation on 10/25 the resident opened the stood in the doorway.  During interview on 10 administrative nurse If effects for the Clonaz not care planned. Statcheir phones or the drastation to see what side specific medications.  The facility failed to madverse side effects the continuous adverse side effects the care planned when the care planned is specific medications.  The Physician's Ord 10/1/12 for resident # dementia (memory proposed planned in the care brovascular accide (blood sugar problem artery disease (build to vessels); hypertension osteoarthritis (sore be hyperlipidemia (high form).	chavior Sheet showed staff and did a psychotropic ent, but failed to indicate rs staff were to monitor for 1/12 at 8:03 A.M. revealed the door to his/her room and 1/25/12 at 10:37 A.M. Do acknowledged the side epam and Meclazine were ff used the application on ug book at the nurse's de effects to monitor for 1/12 at 8:03 A.M. The side epam and Meclazine were ff used the application on ug book at the nurse's de effects to monitor for 1/12 at 8:03 A.M. The side epam and Meclazine were ff used the application on ug book at the nurse's de effects to monitor for 1/12 at 10:37 A.M. The side epam and Meclazine were ff used the application on ug book at the nurse's de effects to monitor for 1/12 at 10:37 A.M. The side epam and Meclazine were ff used the application on ug book at the nurse's de effects to monitor for 1/12 at 10:37 A.M. The side epam and Meclazine were ff used the side epam and Meclazine were fitted the side epam and Meclazine were ff used the side epam and Meclazine were fitted the side epam and Me	,	329			
	8/8/12 revealed the rememory problems; wa	Im Data Set (MDS) dated esident had long/short term as able to recall staff derately impaired cognitive					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WING	<b>3</b>		10/3	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	depression) for mood antipsychotic/antidept.  The clinical record lad side effects for all of the resident.  Staff interview on 10/2 licensed nursing staff the medication side ebook located at the numbrone, or could be located at the facility-provided production side effect or facility-provided program Lippin Some of the charge numbrone application on their permedication on their permedication side effect report any unusual syor long term care suppreviewed medication notified the practitione nurse did a monthly resident. Facility staff the completion of the addressed medication summary.	n making; scored 3 (mild; and received ressant medications.  sked evidence of medication he medications staff gave  23/12 at 9:00 A.M. with H stated she/he obtained ffects from a nursing drugursing station, on her/his oked up on the computer.  23/12 at 9:05 A.M. with ted staff could obtain the from the nurse or the the nursing station.  23/12 at 9:05 A.M. with ted staff could obtain the from the nurse or the the nursing station.  23/12 at 9:05 A.M. with ted staff could obtain the from the nurse or the the nursing station.  23/12 at 9:05 A.M. with ted staff could obtain the from the nurse or the the nursing station.  23/12 at 9:05 A.M. with ted staff could obtain the nurse or the nurse or the the nursing station.  23/12 at 9:05 A.M. with ted staff could obtain the nurse or the nurse of the charge nurse ervisor. Facility staff if symptoms arose and the nursing summary on each of used a tickler file to assure monthly summary. Staff	F3	329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3:	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 329	Continued From page effects for this resider		F	329			
	10/1/12 for resident # hypertension (high blo (low calcium in the blo fat in the blood), iron o in the blood), depress leukocytosis (high wh dementia (memory pr	ite blood cells in the blood),					
	for Mental Status (BIN	revealed a Brief Interview  AS) score of 2 (severe ; and received antipsychotic					
		sked evidence of medication he medications staff gave					
	licensed nursing staff the medication side ed book located at the nu	23/12 at 9:00 A.M. with H stated she/he obtained ffects from a nursing drug ursing station, on her/his oked up on the computer.					
	direct care staff R staf	ts from the nurse or the					
		policy entitled Monitoring of cts (undated) directed staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E015	B. WING	·		10/3	0/2012
	ROVIDER OR SUPPLIER	тси		330 \$	T ADDRESS, CITY, STATE, ZIP CODE S VERMONT PO BOX 268 NSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371 SS=F	for monitoring of all monline program Lippin Some of the charge mapplication on their permedication on their permedication side effect report any unusual syor long term care supreviewed medication notified the practitione nurse did a monthly resident. Facility staff the completion of the addressed medication summary.  The facility failed to meffects for this resided 483.35(i) FOOD PROSTORE/PREPARE/S  The facility must - (1) Procure food from considered satisfacto authorities; and	andbook at the nurse's desk nedication side effects or the ncott's Nursing Drug Advisor. nurses had a triage ersonal phones to look up ts. Staff members would emptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each f used a tickler file to assure monthly summary. Staff in side effects in the nonitor medication side int.  OCURE, ERVE - SANITARY	F3	329			
	by: The facility reported a Based on observation interview the facility fa	is not met as evidenced a census of 29 residents. n, record review, and staff ailed to store/label open food ailed to maintain clean					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION  LDING	(X3) DATE S COMPL	
		17E015	B. WIN	IG	10	/30/2012
	OVIDER OR SUPPLIER	TCU		STREET ADDRESS, CITY, STATE, ZIP O 330 S VERMONT PO BOX 268 RANSOM, KS 67572	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 371	while assisting reside for one of four days of Findings included:  - Observation on 10/opened undated/unla which contained a 2 p 2# bag of Corn Flake cereal; 2 small desse not covered or labele open unlabeled bag of chicken pieces, and he Staff interview on 10/Dietary Staff DD state with a date when open the Policy and Procedure for Left Owere left over foods to containers with lids, latter efrigerator.  Observation on 10/22 three spout milk dispense spout onto the containers with lids with a date when open spout onto the containers with lids with the refrigerator.  Observation on 10/22 three spout milk dispense spout onto the containers with lids with the containers with lids with the spout onto the containers with lids with the spout of t	and failed to wash hands ants in the main dining room in site of the survey.  22/12 at 8:00 A.M. revealed beled food in a cabinet bound (#) bag of Cheerios, so, 2# bag of Rice Crispy in the current of chicken patties and namburger buns.  22/12 at 10:00 A.M. with end staff were to label food ined.  32/12 at 10:00 A.M. with end staff were to label food ined.  32/12 at 8:05 A.M. revealed a genser dripped milk under bunter; noted under the other milk build up; the large of in splatter on the white in blender's base had food  23/12 at 11:35 A.M. with end kitchen staff were ing the kitchen equipment; ind daily assignments and	F:	371		
		at staff completed the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WINC	€		10/3	0/2012
	OVIDER OR SUPPLIER	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 10 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	schedule.  Observation on 10/22 direct care staff P tou resident, who she/he then pushed her/his h forehead. She/he their esident at the table a glasses by the rim. Sidrinking end of the assup/down the end to sigave the resident a dinition the dining room a hands, and cut the brhanded it to several distribution. Staff interview on 10/2 administrative nursing need to wash hands but should not serve I touch the drinking end rim of the drinking glad.  Observation on 10/22 direct care staff O refirem her/his left ear e ear piece back into he a cup of coffee for a refirm hands.  Staff interview on 10/2.	dure undated/untitled monthly kitchen cleaning  2/12 at 11:37 A.M. revealed ched an un-sampled fed, on the shoulder and nair back off her/his in moved over to the another and picked up her/his ne/he then touched the straw and ran her/his fingers traighten it out and then rink through the straw. At en brought a loaf of bread and held it with her/his bare lead, then buttered it, and different residents.  25/12 at 10:37 A.M. with g staff D stated staff did not between feeding residents, oread with bare hands, ds of the straw or touch the less.  2/12 at 11:43 A.M. revealed moved the audio ear piece xamined it and replaced the ear/his left ear twice; obtained resident, and did not wash	F3	371			
		ted staff should wash hands eaving the dining room; and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		17E015	B. WIN	IG		10/3	0/2012
	OVIDER OR SUPPLIER	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425 SS=E	worn by staff before the their meals.  Staff interview on 10/2. Administrative Nursin her/his expectation the after taking out and retheir head sets before meal.  The policy and proced revised date of 9/07 meal.  The policy and proced revised date of 9/07 meal.  The policy and proced revised date of 9/07 meal.  The facility failed to lake the policy in the facility failed to lake the policy failed to lake	piece on the head sets hey assist residents with  25/12 at 11:30 A.M. with g Staff D stated it was at staff wash their hands e-inserting the ear piece of a sassisting residents with  dure for Handwashing with a evealed staff should wash esident contact; after contact with the immediate vicinity of the  abel open foods; failed to ent clean; and failed to meals in a sanitary manner.  IACEUTICAL SVC -  DURES, RPH  ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse.  e pharmaceutical services that assure the accurate dispensing, and rugs and biologicals) to meet		425			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E015	B. WIN	G	<del></del>	10/3	0/2012	
	OVIDER OR SUPPLIER	TCU		330	T ADDRESS, CITY, STATE, ZIP CODE S VERMONT PO BOX 268 NSOM, KS 67572			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 425	a licensed pharmacis	loy or obtain the services of t who provides consultation provision of pharmacy	F	425				
	by: The facility identified and the sample include observation, record refacility failed to obtain	a census of 29 residents ded 23 residents. Based on eview and interview, the blood pressure parameters 1,#15,#21,#2) of 10 residents ons.						
	Data Set (MDS) 3.0 of Brief Interview for Me 3, severely impaired. Independent with Action and rejection of care the assessment period antianxiety, antidepremedications to the result of the Medication Admit dated 10/1/12 recorded Atenolol (high blood programmedications) day for hypertension MAR lacked any blood staff to hold the medical index of the Medication Admit dated 10/1/12 recorded Atenolol (high blood programmedications) day for hypertension MAR lacked any blood staff to hold the medical index of the Market and Mar	vities of Daily Living (ADL), occurred 1 to 3 days during d. Staff administered ssant, and diuretic sident.  nistration Record (MAR) ed the physician's order for pressure medication) every (high blood pressure). The d pressure parameters for cation.  dated 4/9/12 lacked any						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	ROVIDER OR SUPPLIER	тси	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425	licensed nursing staff resident blood pressure resident's doctor orderesident was on a melicensed staff used the blood pressure was to medication, and if state were to document and blood pressure and nursing staff H stated standing physician's when to hold a blood other medications the blood pressure.  The facility lacked a predication paramete.  The facility failed to president's blood pressure.  - Resident #25's qual (MDS) 3.0 dated 10/1 Interview for Mental Smildly impaired. The land setup with dressi with all other areas of (ADL). Staff administrantidepressant, anticemedications to the retailed. The Medication Admidated 10/1/12 records. Lisinopril, Metoprolol, pressure medications.	In 10/24/12 at 9:34 A.M., It H stated staff obtained all ares every week unless the ered otherwise. When the edication for blood pressure, eir own judgment if the cool ow to give or hold a suff held a medication they do monitor the resident's cotify the physician. Licensed at the facility did not have corders of parameters for pressure medication or for at may affect a resident's colicy for blood pressure rs.  Interview of the provided a Brief Status (BIMS) score of 8, resident required supervision and was independent and Activities of Daily Living ered antianxiety, coagulant, and diuretic	F	425			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G		10/30	0/2012
	OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425	Continued From page	36	F	425			
	pressure parameters medication.	for staff to hold the					
	The Standing Orders blood pressure medic	dated 4/9/12 lacked any ation parameters.					
	licensed nursing staff residents blood press resident's doctor orderesident was on a melicensed staff used the blood pressure was to medication, and if stated were to document and blood pressure and nursing staff H stated standing physician's owhen to hold a blood other medications that blood pressure.  The facility lacked a predication parameter	rovide parameters for this					
	10/01/12 recorded a control (high blood pressure) to give the resident M medication) 50 milligrous tachypnea (rapid breat resident's blood pressure)	cian's Order sheet dated diagnosis of hypertension . The physician ordered staff etoprolol (a blood pressure ams twice daily for athing) and monitor the sure weekly. The clinical ressure parameters for staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION  LDING	(X3) DATE S COMPL	
		17E015	B. WING	G	.   10	/30/2012
	OVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, 2 330 S VERMONT PO BOX 268 RANSOM, KS 67572	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 425	that the resident took the resident's blood p monitoring weekly. The staff with parameters Metoprolol.  Observation on 10/25 the resident sat in the a wheelchair feeding.  During an interview of administrative nursing did not have a policy pressure parameters medications which after Some residents had as by the physician, but.  The facility failed to perform this resident #30's Physician in the parameters for this resident #30's Physician in the parameters for the physician in the parameters for this resident #30's Physician in the parameters for the physician in the parameters for this resident #30's Physician in the parameters for the parameters for the parameters for the parameters for the physician in the parameters for t	dministered dications.  3/16/12 failed to direct staff Metoprolol which effected ressure and needed ne care plan failed to provide for this resident's  3/12 at 8:05 A.M. revealed edining room at the table in himself/herself.  3/12 at 10:37 A.M. g staff D reported the facility which directed staff on blood and when to hold fected blood pressure. Specific parameters ordered not this resident.	F	425		
	medication that effect milligrams daily for hi check the resident's t physician did not list l	and ordered Nifedipine (a led blood pressure) 60 gh blood pressure and to blood pressure weekly. The blood pressure parameters.  In Data Set (MDS) 3.0 dated resident received an				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRU	CTION	(X3) DATE S COMPLE	
		17E015	B. WIN	3		10/	/30/2012
	OVIDER OR SUPPLIER	тси			S, CITY, STATE, ZIP CODE NT PO BOX 268 S 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SH SSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	each out of the 7 day  The comprehensive of not direct staff on who blood pressure medic doctor, and lacked blood pressure on 10/25 the resident opened to stood in the doorway.  During interview on 1 administrative nurse is record lacked blood precility did not have a when to hold blood precility failed to precipitation.  The facility failed to precipitation of the physician.	ianxiety medication 7 days so prior to the assessment.  care plan dated 9/20/12 did en to hold the resident's cation, when to call the bood pressure parameters.  6/12 at 8:03 A.M. revealed the door to his/her room and	F	425			
	10/1/12 for resident # hypertension (HTN; h The Significant Change (MDS) dated 9/26/12 for Mental Status (BII cognitive impairment) The POS dated 10/1/ Metoprolol 25 milligrate for HTN; Isosorbide M	ge Minimum Data Set revealed a Brief Interview MS) score of 2 (severe					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E015	B. WIN	G		10/3	0/2012
	OVIDER OR SUPPLIER	тси	•	330	T ADDRESS, CITY, STATE, ZIP CODE S VERMONT PO BOX 268 NSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 425	licensed nursing staff resident blood pressuresident's doctor orderesident was on a melicensed staff used the blood pressure was to medication, and if state were to document and blood pressure and not facility did not have stated parameters which directly blood pressure medications that may pressure.  Staff interview on 10// licensed nursing staff checked the blood premedication aide (CM/(BP) in the evening; the nurse for readings of	24/12 at 9:34 A.M. with H stated staff obtained all ares every week unless the ered otherwise; when the edication for blood pressure, eir own judgement if the co low to give or hold a ff held a medication they d monitor the resident's otify the physician; the tanding physician's orders of ected staff when to hold a cation or for other affect a resident's blood  25/12 at 9:54 A.M. with I stated the charge nurse essure weekly; the certified A) checked blood pressure the CMA would inform the go and above diastolic.	F	425	DEFICIENC!)		
	- The Physician's Ord 10/1/12 for resident # hypertension (HTN; h	der Sheet (POS) dated 21 revealed a diagnosis of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E015	B. WIN	G		10/3	0/2012	
	ROVIDER OR SUPPLIER	тси	1	330	ET ADDRESS, CITY, STATE, ZIP CODE S VERMONT PO BOX 268 NSOM, KS 67572			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 425	memory problems; w names/faces; and ha cognitive skills for dail of the POS dated 10/1/Cozaar 100 milligram for HTN; Amlodipine Atenolol 100 mg PO blood pressure.  Staff interview on 10/licensed nursing staff resident blood pressure resident was on a melicensed staff used the blood pressure was to medication, and if stawere to document and blood pressure and in facility did not have separameters for when medication or for other affect a resident's blood pressure was the medication or for other affect a resident's blood pressure of the blood pressure of the blood pressure of the blood pressure of the blood pressure for readings of the facility lacked a polood pressure medication and pressure medication pressure press	as able to recall staff d moderately impaired ally decision making.  12 revealed orders for so (mg) by mouth (PO) daily 10 mg PO daily for HTN; daily for HTN; and weekly  24/12 at 9:34 A.M. with a H stated staff obtained all bures every week unless the extendication for blood pressure, eir own judgement if the colow to give or hold a suff held a medication they d monitor the resident's otify the physician; the tanding physician's orders of to hold a blood pressure er medications that may od pressure.  25/12 at 9:54 A.M. with a stated the charge nurse essure weekly; the certified A) checked blood pressure he CMA would inform the go and above diastolic.	F	425				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G_		10/30	0/2012
	OVIDER OR SUPPLIER	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 130 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 425	Continued From page	41	F	425			
	Set (MDS) 3.0 dated resident as severely or resident required total transfers, locomotion dressing, toilet use, plathing, and required for bed mobility and elinsulin, antipsychotic medications to the resident and the medication Admindated 10/1/12 recorded Lotrel (high blood presonal for hypertension (high lacked any blood presonal for hypertension (high lacked any blood presonal for hypertension).  The Standing Orders blood pressure medication.  The Standing Orders blood pressure medication and interview of licensed nursing staff resident's blood pressure was to medication, and if stated were to document and blood pressure and nursing staff H stated standing physician's owner to hold a blood	cognitively impaired. The I staff assistance for on and off the unit, ersonal hygiene and extensive staff assistance ating. Staff administered and antidepressant sident.  Inistration Record (MAR) ed the physician's order for assure medication) every day a blood pressure). The MAR assure parameters for staff to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E015	B. WING		10/3	0/2012
	OVIDER OR SUPPLIER	_TCU	33	EET ADDRESS, CITY, STATE, ZIP CODE 80 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	Continued From page	e 42	F 425			
	The facility lacked a pmedication paramete	policy for blood pressure rs.				
F 428 SS=E	resident's blood press	GIMEN REVIEW, REPORT	F 428			
	• •	each resident must be e a month by a licensed				
	the attending physicia	report any irregularities to an, and the director of ports must be acted upon.				
	by: The facility identified The sample for medic residents. Based on c and staff interview, th failed to report medic	is not met as evidenced a census of 29 residents. cation review included 10 observation, record review, le facility consultant GG ation regime irregularities for 21, 4, 2, 24, 3, and #30) ole.				
	Data Set (MDS) 3.0 c	ificant change Minimum dated 9/12/12 recorded a ental Status (BIMS) score of The resident was				
	independent with Act	ivities of Daily Living (ADL),				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	_DIN(		(X3) DATE SUF	
		17E015	B. WIN	G_		10/3	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	and rejection of care of the assessment perio antianxiety, antidepre medications to the res	occurred 1 to 3 days during d. Staff administered ssant, and diuretic sident.	F	428			
		cked evidence of medication monitored for any of the e the resident.					
	7/26/12, 8/25/12, 9/27	g Regimen Reviews dated 7/12, and 10/18/12 failed to edication side effects for this					
	licensed nursing staff had questions or conceffects they consulted online to Lippincott's Italked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the facindividualized medicathe resident.  Unable to contact phasinterview on 10/29/12  The facility-provided particular actions of the phasinterview	f H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual ne resident before staff gave sed nursing staff H cility did not have tion side effects listed for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	ULTIPLE CONSTRUCTION  LDING	(X3) DATE S COMPL	
		17E015	B. WIN	IG	10	/30/2012
	OVIDER OR SUPPLIER	TCU		STREET ADDRESS, CITY, STATE, ZIP 330 S VERMONT PO BOX 268 RANSOM, KS 67572	•	70072012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 428	for monitoring of all monline program Lippin Some of the charge mapplication on their permedication on their permedication side effect report any unusual syor long term care supreviewed medication notified the practitione nurse did a monthly resident. Facility staff the completion of the addressed medication summary.	andbook at the nurse's desk nedication side effects or the ncott's Nursing Drug Advisor. It was a triage ersonal phones to look up ts. Staff members would emptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each f used a tickler file to assure monthly summary. Staff in side effects in the	F	428		
	(MDS) 3.0 dated 8/8/ term memory problem faces, and had mode making cognitive skill antianxiety and antide resident.  The clinical record lac side effects for any of the resident.	epressant medications to the cked evidence of medication the medications staff gave				
	7/19/12, 8/30/12, 9/20	g Regimen Reviews dated 0/12, and 10/18/12 failed to edication side effects for				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G	·	10/30	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 130 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	licensed nursing staff had questions or conceffects they consulted online to Lippincott's I talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or staff telephone	n 10/24/12 at 9:58 A.M., H stated when the nurses cerns about medication side the medication book, went Nursing Drug Advisor, or ver with other nurses. If H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual ne resident before staff gave	F	428			
	acknowledged the fac individualized medica the resident.	cility did not have tion side effects listed for armacy consultant GG for					
	Medication Side Effect to refer to the drug has for monitoring of all monline program Lippin Some of the charge napplication on their permedication side effect report any unusual sy or long term care suppreviewed medication notified the practitione nurse did a monthly resident. Facility staff	ersonal phones to look up ts. Staff members would imptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each f used a tickler file to assure monthly summary. Staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E015	B. WIN			40/2	0/2042
	ROVIDER OR SUPPLIER	I		33	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 LANSOM, KS 67572	10/30	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428		nacy staff GG failed to le effects to monitor for this	F	428			
	(MDS) 3.0 dated 10/1 Interview for Mental S mildly impaired. The and setup with dressi with all other areas of (ADL). Staff administe	pagulant, and diuretic					
		cked evidence of medication f the medications staff gave					
	7/19/12, 8/23/12, 9/2	ng Regimen Reviews dated 7/12, and 10/18/12 failed to edication side effects for					
	licensed nursing staff had questions or con- effects they consulted online to Lippincott's talked the situation of Licensed nursing staff	n 10/24/12 at 9:58 A.M., H stated when the nurses cerns about medication side d the medication book, went Nursing Drug Advisor, or wer with other nurses. H also consulted his/her for medication side effect					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE LDING	E CONSTRUCTION	(X3) DATE SUP COMPLET	
		17E015	B. WIN	IG		10/3	0/2012
	OVIDER OR SUPPLIER	TCU		330	ET ADDRESS, CITY, STATE, ZIP CODE OS VERMONT PO BOX 268 INSOM, KS 67572		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	information. Licensed the resident acted or the nurse assessed the medication. Licen acknowledged the facindividualized medicathe resident.  Unable to contact phainterview on 10/29/12  The facility-provided phedication Side Effectorefer to the drug hafor monitoring of all monline program Lippin Some of the charge mapplication on their permedication side effectoreport any unusual syor long term care suppreviewed medication notified the practitione nurse did a monthly president. Facility staff the completion of the addressed medication summary.  The consultant pharmidentify the lack of side resident's medications.  Resident #2's significations.	nursing staff H stated when seemed different than usual he resident before staff gave sed nursing staff H cility did not have tion side effects listed for at 1:55 P.M.  Poolicy entitled Monitoring of cts (undated) directed staff andbook at the nurse's desk hedication side effects or the foott's Nursing Drug Advisor. Hurses had a triage tersonal phones to look up tts. Staff members would temptoms to the charge nurse ervisor. Facility staff if symptoms arose and the as pertinent. The charge nursing summary on each of used a tickler file to assure monthly summary. Staff in side effects in the charge staff GG failed to be effects to monitor for this second to the cognitively impaired. The	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION  DING	(X3) DATE S COMPL	
		17E015	B. WING	G	10	/30/2012
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP O 330 S VERMONT PO BOX 268 RANSOM, KS 67572	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 428	for bed mobility and einsulin, antipsychotic medications to the resident.  The clinical record lad side effects for any of the resident.  The pharmacist's Dru 10/18/12, 9/27/12, 8/2 identify the lack of me staff to refer to.  During an interview o licensed nursing staff had questions or cone effects they consulted online to Lippincott's talked the situation of Licensed nursing staff telephone application information. Licensed the resident acted or the nurse assessed the medication.  Unable to contact phainterview on 10/29/12  The facility-provided in Medication Side Effect to refer to the drug has for monitoring of all medications of the resident acted or the drug has for monitoring of all medications of the drug has for monitoring of all medications of the resident acted or the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the resident acted or the nurse assessed the medication of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the resident acted or the nurse assessed the medication of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medications of the drug has for monitoring of all medicat	on and off the unit, ersonal hygiene and extensive staff assistance rating. Staff administered and antidepressant sident.  Cked evidence of medication the medications staff gave  g Regimen Reviews dated 23/12 and 7/26/12 failed to redication side effects for  In 10/24/12 at 9:58 A.M.,  H stated when the nurses cerns about medication side of the medication book, went hursing Drug Advisor, or ver with other nurses.  If H also consulted his/her for medication side effect nursing staff H stated when seemed different than usual; the resident before staff gave  armacy consultant GG for at 1:55 P.M.  Poolicy entitled Monitoring of the continuation of the continuati	F	428		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		17E015	B. WIN	G		10/3	0/2012
	OVIDER OR SUPPLIER	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 428	application on their permedication side effect report any unusual sy or long term care sup reviewed medication notified the practitionenurse did a monthly resident. Facility staff the completion of the addressed medication summary.  The consultant pharm that the facility did no resident's medications  - Resident #4's quart (MDS) 3.0 dated 8/15 Interview for Mental Swhich indicated intact recorded the resident assistance for locomorpersonal hygiene, and for bed mobility, trans Staff gave the resider anticoagulant (prever (increased fluid release The clinical record lace	ersonal phones to look up ts. Staff members would imptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each if used a tickler file to assure monthly summary. Staff in side effects in the  hacy staff failed to identify it monitor side effects for this is.  erly Minimum Data Set i/12 recorded the Brief status (BIMS) score was 15 cognition. The MDS required total staff off on and off the unit and id extensive staff assistance ifers, dressing and toilet use. int insulin, antidepressant, its blood clots) and diuretic	F	428	DEFICIENCY		
	10/18/12, 9/27/12, 8/2	g Regimen Reviews dated 23/12 and 7/26/12 failed to edication side effects for this					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	ROVIDER OR SUPPLIER	_TCU	<b>,</b>	330 \$	T ADDRESS, CITY, STATE, ZIP CODE S VERMONT PO BOX 268 ISOM, KS 67572	13.3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	licensed nursing staft had questions or con effects they consulted online to Lippincott's talked the situation or Licensed nursing statelephone application information. Licensed the resident acted or the nurse assessed to the medication. Licensed the medication. Licensed the resident acted or the nurse assessed to the medication. Licensed the resident acted or the nurse assessed to the medication. Licensed the medication. Licensed the medication. Licensed the medication acknowledged the faindividualized medication the resident.  Attempted to call but consultant GG for into P.M.  The facility-provided Medication Side Effector refer to the drug has for monitoring of all nonline program Lipping Some of the charge rapplication on their predication side effects.	on 10/24/12 at 9:58 A.M.,  If H stated when the nurses cerns about medication side d the medication book, went Nursing Drug Advisor, or wer with other nurses.  If H also consulted his/her in for medication side effect d nursing staff H stated when seemed different than usual the resident before staff gave insed nursing staff H cility did not have altion side effects listed for unable to reach pharmacy the erview on 10/29/12 at 1:55  policy entitled Monitoring of cts (undated) directed staff andbook at the nurse's desk medication side effects or the incott's Nursing Drug Advisor.	F	428	DEPICIENCY)		
	notified the practition nurse did a monthly resident. Facility stat	if symptoms arose and er as pertinent. The charge nursing summary on each ff used a tickler file to assure monthly summary. Staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G	<del></del>	10/3	0/2012
	OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 ANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page The consultant pharm the lack of side effect resident's medications	nacy staff failed to identify s to monitor for this	F	428			
	10/01/12 recorded dia pain, fibromyalgia and effect the musculoske to cause pain). The pi give the resident Tyle times daily for pain ar patch, one half of a pabed time. The physici administer Exelon (for bowels), Prilosec (for (treatment for uric aci high blood pressure), insulins (for blood sugarther quarterly Minimus 8/08/12 documented	gars) to the resident.  m Data Set (MDS) 3.0 dated the resident had pain almost					
	constantly and in the assessment the pain The resident received medications.	limited day to day activities.					
	2/29/12 documented pain of the knees and	sment (CAA) for pain dated the resident had chronic shoulders, received Tylenol used a lidoderm patch (a on patch) at night.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		DNSTRUCTION	(X3) DATE SUF	
		17E015	B. WIN	G		10/3	0/2012
	ROVIDER OR SUPPLIER	тси	•	330 S \	ADDRESS, CITY, STATE, ZIP CODE /ERMONT PO BOX 268 OM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 428	that the resident had did not provide a descripain. Staff did not car scheduled Tylenol 32 daily for pain or the lic care plan did not direct effectiveness of the pplan lacked appropriate pain interventions. Staffects for staff to most Exelon, Miralax, Prilos and insulins.  The clinical record corregimen reviews from failed to identify the number direct on the use of perfect monitoring for Lenot direct staff on what monitor for related to Prilosec, Allopurinol, Lantus.  Observation on 10/25 the resident sat in the a wheelchair feeding.  During interview on 1 administrative nursing medication regimen reconsultant did not incresident's care plan and school of the staff of th	B/16/12 failed to direct staff pain almost constantly and cription of the resident's e plan the resident's 5 milligrams three times doderm patch for pain. The ct staff to monitor for the ain medications. The care are non-pharmacological aff failed to include side nitor as related to the sec, Allopurinol, Metoprolol main medications, for side ain medications, for side ain medications, for side ain medications, for side aid effects staff to the Exelon, Miralax, Metoprolol, Novolog and are dining room at the table in himself/herself.	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLETI	
		17E015	B. WIN	IG		10/30	0/2012
	OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Continued From page	e 53	F	428			
		Itant GG failed to identify the iffect monitoring for this					
	(MDS) 3.0 dated 8/15 resident with short an problems. The reside						
	(CAA) for antipsychot documented the resic psychotropic medicat						
	failed to direct staff or displayed or that the care plan lacked direct behaviors or for side of Zyprexa. The care plan	eare plan dated 8/23/12 In what behavior the resident resident took Zyprexa. The ection for staff to monitor effects related to taking an did not direct staff on the rning (warning of hazardous the use of a drug) for					
	The United States (U-Administration (FDA)	S) Food and Drug issued BBW for Zyprexa					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI				
		17E015	B. WIIV	<u> </u>		10/3	0/2012
	ROVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		33	REET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Continued From page indicated residents w psychosis treated with were at an increased	ith dementia related h anti-psychotic medications	F	428			
		n's Order Sheet ordered staff yprexa 2.5 milligrams every					
	-	navior monitoring by shift for stive to cares, physically					
	regimen reviews from failed to identify the n	ntained monthly medication 1 1/26/12-10/25/12 which eed for specific side effect to identify the Black Box for Zyprexa.					
	Observation on 10/25 the resident slept in b	5/12 at 8:02 A.M. revealed ed.					
	administrative nursing resident started taking staff did not care plan after the last MDS was acknowledged the ca	g Zyprexa on 7/23/12 and the resident for the Zyprexa					
	The consultant pharm	nacy staff GG failed to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E015	B. WIN			40/2	0/0040
	COVIDER OR SUPPLIER	L		3:	EET ADDRESS, CITY, STATE, ZIP CODE 30 S VERMONT PO BOX 268 PANSOM, KS 67572	10/3	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	, ,	e 55 ack of monitoring for this ychotic medication with a	F	428			
	10/01/12 recorded sta 25 milligrams three tii	rsician's Order Sheet dated aff to administer Meclizine mes daily for dizziness and grams three times daily for					
	9/12/12 recorded the antipsychotic and ant	m Data Set (MDS) 3.0 dated resident received an ianxiety medication 7 days s prior to the assessment.					
	psychotropic medicat the resident recently hospital stay prior to a psychotropic medicat diagnoses of anxiety	Area Assessment (CAA) for ions dated 6/26/12 recorded returned from a psychiatric admission and took several ions. The resident had and depression. The rapro and Clonazepam for					
	alteration directed sta and monitor for side e and perform the beha did not list the potenti medication staff shou comprehensive care						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		17E015	B. WIN	IG _		10/3	0/2012
	OVIDER OR SUPPLIER	тси	1	3	REET ADDRESS, CITY, STATE, ZIP CODE 330 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	, ,	t direct the staff on what	F	428			
	monitoring of behavio	Management Plan showed rs and then a psychotropic ent, but did not indicate specific for which					
	review by the consultate failed to identify the n	nthly medication regimen ant pharmacy dated 9/27/12, eed for the facility to monitor fic side effects from the nd Clonazepam.					
		/12 at 8:03 A.M. revealed he door to his/her room and					
	effects for the Clonaz not care planned. Sta their phones or the dr station to see what sig	O acknowledged the side epam and Meclazine were ff use the application on ug book at the nurse's de effects to monitor for The consultant pharmacy ans for individualized					
	•	nacy staff GG failed to lock of monitoring for this s.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETE	
		17E015	B. WIN	G	<del> </del>	10/30	0/2012
	ROVIDER OR SUPPLIER	тси		3	REET ADDRESS, CITY, STATE, ZIP CODE 130 S VERMONT PO BOX 268 RANSOM, KS 67572		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page	÷ 57	F	428			
	10/1/12 for resident # dementia (memory pr Alzheimer's type (mer cerebrovascular accid (blood sugar problem artery disease (build a vessels); hypertension osteoarthritis (sore bothyperlipidemia (high f The Quarterly Minimus 8/8/12 revealed the rememory problems; wanames/faces; had moskills for daily decision depression) for Mood antipsychotic/antideporthe clinical record lad side effects for any of the resident.  The Medication Regin 8/23, 9/20, 10/18/12 resident.  Staff interview on 10/2 licensed nursing staff the medication side e book located at the nuphone, or can be look.  Staff interview on 10/2 direct care staff R sta	at levels in the blood).  Im Data Set (MDS) dated esident had long/short term as able to recall staff derately impaired cognitive in making; scored 3 (mild is, and received					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SUP COMPLET	
		17E015	B. WIN	IG		10/3	0/2012
	OVIDER OR SUPPLIER	тси		33	EET ADDRESS, CITY, STATE, ZIP CODE 0 S VERMONT PO BOX 268 ANSOM, KS 67572	10/0	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Attempted interview of revealed unable to confor interview.  The facility-provided predication Side Effectives		F	428			
	for monitoring of all monline program Lippin Some of the charge mapplication on their permedication side effect report any unusual syor long term care suppreviewed medication notified the practitione nurse did a monthly resident. Facility staff	nedication side effects or the acott's Nursing Drug Advisor. Burses had a triage ersonal phones to look up ats. Staff members would amptoms to the charge nurse ervisor. Facility staff if symptoms arose and er as pertinent. The charge nursing summary on each fused a tickler file to assure monthly summary. Staff					
		nacy staff GG failed to feets monitoring for this as.					
	10/1/12 for resident # hypertension (high blo (low calcium in the blo	der Sheet (POS) dated 15 revealed diagnoses of bod pressure), hypocalcemia bod), hyperlipidemia (high deficiency anemia (low iron					

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` ′			(X3) DATE SUF	
	17E015	B. WIN	G	<del></del>	10/3	0/2012
OVIDER OR SUPPLIER  MEMORIAL HOSPITAL L	тси		3:	30 S VERMONT PO BOX 268		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	_D BE	(X5) COMPLETION DATE
in the blood), depress leukocytosis (high wh dementia (memory pr (mood disorder), and movement).  The Significant Chang (MDS) dated 9/26/12 for Mental Status (BIN cognitive impairment) and antidepressant m  The clinical record lad side effects for any of the resident.  The Medication Regin 8/23, 9/20, and 10/18, irregularities.  Staff interview on 10/2 licensed nursing staff the medication side e book located at the nuphone, or can be look  Staff interview on 10/2 direct care staff R statican be obtained from located at the nursing  Attempted interview or revealed unable to cofor interview.  The facility-provided process of the static content of the st	ite blood cells in the blood), oblems), sundowners constipation (irregular bowel ge Minimum Data Set revealed a Brief Interview MS) score of 2 (severe; and received antipsychotic redications.  Eked evidence of medication the medications staff gave men Review dated 7/19, 1/12 revealed no  23/12 at 9:00 A.M. with H stated she/he obtained ffects from a nursing drugursing station, on her/his red up on the computer.  23/12 at 9:05 A.M. with the medication side effects the nurse or the drug book station.  In 10/29/12 at 1:55 P.M. Intact pharmacy consultant policy entitled Monitoring of	F	428			
to refer to the drug ha	ndbook at the nurse's desk					
	CONIDER OR SUPPLIER  MEMORIAL HOSPITAL L  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From page in the blood), depress leukocytosis (high wh dementia (memory pr (mood disorder), and movement).  The Significant Chang (MDS) dated 9/26/12 for Mental Status (BIM cognitive impairment) and antidepressant m  The clinical record lac side effects for any of the resident.  The Medication Regir 8/23, 9/20, and 10/18, irregularities.  Staff interview on 10/2 licensed nursing staff the medication side er book located at the nu phone, or can be look  Staff interview on 10/2 direct care staff R star can be obtained from located at the nursing  Attempted interview or revealed unable to co for interview.  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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		: CONSTRUCTION	(X3) DATE SURVEY COMPLETED  10/30/2012	
		17E015					
NAME OF PROVIDER OR SUPPLIER  GRISELL MEMORIAL HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE  330 S VERMONT PO BOX 268  RANSOM, KS 67572			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	ION SHOULD BE COMPLETION HE APPROPRIATE	
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